California's Commission on Health and Safety and Workers' Compensation 1997 report concludes that, ''Especially in industries with high premium rates, the illegally uninsured employer is able to underbid the insured employer. Insured employers are again disadvantaged when taxes are raised to cover costs shifted to government services to assist the injured workers of employers who are illegally uninsured.''

Several other states, including Wisconsin and Colorado, are also using proactive programs to identify uninsured employers using computerized lists of employers and workers' compensation politics. In New York, a 1997 audit by the state comptroller's office revealed that employers owe more than $500 million in overdue unpaid workers' compensation insurance premiums to the State Insurance Fund. Failure to secure workers' compensation insurance is only a misdemeanor offense in New York. In West Virginia, the state has been forced to initiate a series of lawsuits to force payment of more than $100 million in unpaid workers' compensation premiums.

Medical Provider Fraud

Workers' compensation fraud also occurs among medical providers. These forms of fraud evolve as the nature of medical care changes over time. Outright fraud occurs when providers bill for treatments that never occurred or were blatantly unnecessary. Some of the newer forms of medical provider fraud include kickbacks from specialists and other treatment providers to referring physicians, and provider upcoding, where provider charges exceed the scheduled amount. Providers also shift from the less expensive, all-inclusive patient report to supplemental reports, which add evaluations and incur separate charges.

Medical provider schemes include: creative billing—billing for services not performed; self-referrals—medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest; upcoding—billing for a more expensive treatment than the one performed; unbundling—performing a single service but billing it as a series of separate procedures; product switching—a pharmacy or other provider bills for one type of product but dispenses a cheaper version, such as a generic drug.

Newer forms of fraud and abuse occurring under managed care arrangements include: underutilization—doctors receiving a fixed fee per patient may not provide a sufficient level of treatment; overutilization—unnecessary treatments or tests given to justify higher patient fees in a new contract year; kickbacks—incentives for patient referrals; internal fraud—providers collude with the medical plan or insurance company to defraud the employer through a number of schemes.

According to the National Council on Compensation, ''The increased use of managed care for workers' compensation, as well as for other insurance lines, is bringing new twists to old schemes,'' Managed care creates more opportunities for fraud because of the financial relationships and incentives between players.

Although the campaign against California medical mills wiped out a substantial part of medical provider abuse in that state, new cases continue to emerge. In October of 1997, for example, a pharmacist plead guilty to 21 counts of fraudulent workers' compensation insurance billing. The pharmacist increased his revenues by up to 500% per prescription on more than $600,000 of drugs sold over a four year period.

Insult Added to Injury

Because of the assumption of widespread claimant fraud, injured workers who file a workers' compensation claim may be subjected to insulting questions and treated as malingerers and cheats. Under the auspices of ''fraud prevention,'' they may face endless questioning and unnecessary medical examinations. They may be subjected to constant video surveillance by private investors hired to follow their every move. Their employer may refuse to provide light duty work, or take retaliatory actions against them when they return to work. If they look for another job, their application may be screened for prior workers' compensation claims.

Although some of these tactics are used in legitimate attempts to investigate questionable claims, they have also become part of a broad employer attempt to intimidate workers from filing workers' compensation claims. Under the pretext of controlling what has been falsely presented as rampant claimant fraud, injured workers are discouraged form exercising their legitimate rights to workers' compensation benefits. As a recent Michigan study demonstrated, the real problem in workers' compensation is not that too many workers claim benefits, but that too few do so. The study, sponsored by the National Institute for Safety and Health, found that only one in four workers with occupational diseases file for workers' compensation. Unsubstantiated charges of rampant claimant fraud undermine public confidence in the system and discourage legitimately injured workers from seeking the benefits they need and deserve.

In California, a detailed investigation by state auditors found that ''workers' compensation insurers violated workers' rights in about half the claims it audited.'' The violations included ''unacceptably high amounts'' of unpaid benefits, late payments, inaccurate benefit notices and failure to notify injured workers of their rights. In describing the experience of many workers' compensation claimants. The Santa Rosa Press Democrat found that many injured workers slam into a wall of suspicion and distrust that will paralyze them with shame and frustration and delay their recovery. One of the injured workers interviewed by the newspaper commented: ''You get the feeling that even though you have a legitimate complaint and a six-inch scar, you're somehow a malingerer.''

The grossly overstated estimates of claimant fraud have not only subjected injured workers with legitimate claims to fear and intimidation, but have also obscured a more serious look at the workers' compensation system and the benefits it provides. The real question is not why there is so much claimant fraud, but why there is so little. In most states, workers' compensation benefits provide little more than poverty-level existence. Workers often wait weeks and months for payments.

Many employers refuse to provide light duty or alternative jobs for workers who might be able to go back to work in a modified capacity while they continue to recover, so workers are forced to continue on inadequate benefit payments even though they may be able to work in some capacity. Some injured workers lose their jobs or are only offered positions at much lower pay. It is little wonder that so many claimant fraud cases involve workers illegally continuing to accept benefits when they are in fact working at another establishment. Too many times, inadequate benefits put people in desperate straits, and they take desperate measures as a result. A system that leaves people in poverty invites abuse.

The presumption of widespread malingering and dishonesty undercuts any meaningful discussion of the adequacy of benefits and provides a convenient response for those opposed to the benefit increases that are so critically needed in many states. Until the misplaced focus on claimant fraud is overcome, district attorneys will continue to fry the small fish while the big fish go free, and the voting public will remain distracted by anecdotes.

PERSONAL EXPLANATION

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. DAVIS of Illinois. Mr. Speaker, on September 17, 1998, I was unavoidably detained from casting my vote on Roll Call number 448. However, if I had been present, I would have voted ''aye'' on this amendment.

PRESCRIPTION DRUG PRICING

HON. MARION BERRY

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. BERRY. Mr. Speaker, I rise today to announce the formation of the Prescription Drug Task Force.

I have enjoyed working with Representatives ALLEN and TURNER to form the task force.

The task force will work to bring attention to issues involving the costs and availability of prescription drugs.

The task force will serve as a clearinghouse for information on these issues and will host educational forums, briefings, and hearings.

One of the things we will focus on is continuing to hold forums like the one we hosted last week, where members will be given an opportunity to participate in discussions and learn how consumers are being affected by the pricing decisions of pharmaceutical companies.

One thing I would like to talk about tonight is how the most profitable industry in existence (that is legal) and why that industry's practice of making excessive profits from the elderly and uninsured Americans is bad news.

According to industry ratings of Fortune 500 companies—pharmaceutical companies are the most profitable businesses in existence. They made $24.5 billion in profits last year. Pharmaceutical companies had a 17.2 percent return on revenues. That compares to telecommunication companies who had an 8.1 percent, computers and office equipment manufacturers who had 7.3 percent, food and drug stores that made 1.7 percent.

One might think the successful pharmaceutical companies would be of tremendous benefit to American consumers. This couldn't be more wrong.

And unfortunately, while the pharmaceutical companies are making tremendous profits, the American people are being gouged. Thousands of consumers, especially seniors, have found themselves affected by the price of prescription drugs in this country.

Studies that have been conducted by the minority staff of the Government Reform and Oversight Committee for several Members of Congress, including myself, over the last several months. These studies have shown the prices seniors and other consumers are

charged are significantly higher than what pharmaceutical companies charge their favored customers such as HMOs, insurance companies and the Federal Government.

Because of this price gouging, seniors across the country are gathering their friends and traveling to other countries such as Mexico and Canada to purchase prescription drugs because to buy them in our own country, is just too expensive. Why not go somewhere else when you can pay a lower price somewhere else?

Here's the reality—prescription drug prices are higher in the United States than they are in neighboring countries. According to the General Accounting Office (GAO), prescription drugs in the U.S. were priced about 34 percent higher than the same products in Canada.

The average price for products sold in the U.S. was $45.17, ranging from $2.35 (for Deltasone, 5 mg. tablets) to $304.32 (for PCE, 333 mg. tablets). The average price for the same products sold in Canada was $33.78, ranging from $1.29 (for Deltasone) to $211.98 (for PCE). The comparisons were based on data collected from both countries for 121 prescription drugs in the same quantities for each product.

Also, the group Public Citizen conducted a study of eight newly developed antidepressant and antipsychotic medications. They found that the prices for each of these eight drugs were higher in the U.S. than they were in 17 other European and North American countries. That's every country looked at in the study.

The study showed that on average, American prices were twice as high as other countries', and for individual comparisons with other countries, the American price was as much as six times higher.

The consequences are that many individuals who need these new drugs, for financial reasons, are not getting the treatment they need.

GAO says the reason for this differential in the drug prices in the two countries is because Canadian law controls prices of both new drugs entering its market and any increases in prices of pharmaceuticals already on the market.

If the manufacturers see profits in countries with price controls and/or government purchasing plans, why do they charge higher prices elsewhere?

When consumers in one area cannot buy in another, the seller may be able to increase its profits by engaging in what economists call price discrimination. That is what is going on in our country, pure and simple, price discrimination. And what this price discrimination amounts to is our seniors are being ripped off.

Mr. Speaker, if someone were going around stealing from seniors in your town or city, stealing right out of their homes and their pockets, people would be outraged. The police would be called and those thieves would be arrested. Then why are we allowing the pharmaceutical companies to rob our seniors? Isn't price discrimination the same thing?

We try to allow people to live longer, but then when a doctor prescribes a drug, the senior can't take it because they can't afford it.

We live in the richest country in the world but we allow people to starve, go without heat, and only take half of their medicine because they can't afford to take the prescribed amount. It is also wrong that seniors have to travel hundreds of miles for medication, they need, often just to stay alive.

PRESCRIPTION DRUG PRICING

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. KENNEDY of Rhode Island. Mr. Speaker, I want to thank Congressman ALLEN and Congressman BERRY for their work in organizing today's special order.

As we are hearing today, many seniors are unable to afford the cost of prescription drugs due to a lack of insurance coverage and excessive drug price inflation.

Ninety percent of Americans over 60 years or older take one or more medications. The days when someone only takes one drug a day are long gone. Today's seniors take three or four drugs a day at least. At the same time, 45 percent of seniors, age 65 and older, do not have prescription drug coverage.

High drug costs, coupled with this lack of coverage, often means making choices between groceries, heating oil, or prescription drugs. How many of our constituents have had to choose between buying certain foods at the grocery store or buying high blood pressure medicine? How many of them had to make sacrifices, just so they could buy their medicines?

For three out of four seniors, prescription drugs represent the highest out-of-pocket medical care cost; only long term care costs more.

The prices of the top selling prescription drugs have risen nearly four times the general rate of inflation between 1985 and the early 1990s. Meanwhile, the Federal Government and the taxpayer spends billions of dollars to help find drugs to treat the diseases of our generation: cancer, Alzheimers, high blood pressure, diabetes, and other chronic conditions.

The industry must do their share as well, and so far they are not doing enough. The pharmaceutical industry is the most profitable industry in the world. In FY 96, it made over $106 billion in sales and revenues and $16.2 billion in sheer profits.

One example of the profits made in the pharmaceutical industry is from the drug TAXOL. TAXOL is an anti-cancer drug that treats breast, lung, and ovarian cancers. It makes $800 million in profits annually. The NIH budget supplied $32 million of the money needed to research this drug. Furthermore, a cancer patient taking TAXOL may pay in excess of $100,000, while the cost to the pharmaceutical company that manufacturers this drug is only about $500 per patient. We pay for the development of these medications, and then pay high prices for their use.

The bill that I introduced this spring with two of my colleagues, Republican Congressman TOM CAMPBELL of California and Independent Congressman BERNIE SANDERS of Vermont, gets at both the need for seniors' prescription drug coverage and the rising costs of these medicines. The bill, called Making Affordable Prescriptions for Seniors Act, will provide up to $500 of such assistance, for any legally marketed prescription drug that is safe and effective according to the FDA.

Also, I am a proud sponsor of the Prescription Drug Fairness Act, by Congressman ALLEN and Congressman BERRY.

The Prescription Drug Fairness for Seniors Act protects senior citizens from drug price discrimination and makes prescription drugs available to Medicare beneficiaries at reduced prices.

The legislation is a ''win-win'' bill because it allows pharmacies that serve Medicare beneficiaries to purchase prescription drugs at the low prices available under the Federal Supply Schedule. The legislation has been estimated to reduce prescription drug prices for seniors by over 40 percent.

It is time that we help alleviate the burden on our nation's seniors and become accountable for rising drug costs. It is only fair that we end the need to make choices between a good nutrition and shelter or critical medication.

PRESCRIPTION DRUG PRICING

HON. THOMAS H. ALLEN

OF MAINE

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. ALLEN. Mr. Speaker, I am pleased to join my colleagues to address a very serious problem, the high price of prescription drugs. We only have a few remaining days left in this Congress. I would like to spend this time discussing the issues which matter to the American people such as HMO reform, reducing class size, and yes, improving the health and well being of our seniors.

As I travel throughout the first district of Maine, people, particularly seniors, share their experiences regarding the high cost of prescription drugs.

The high cost of prescription drugs is particularly difficult for seniors, who use one third of all prescriptions. While the average American under 65 uses only four prescriptions a year, the average senior uses 14 prescriptions a year. Furthermore, most older Americans suffer from more than one chronic condition, such as hypertension, diabetes, arthritis, glaucoma and circulatory problems.

Medicare does not provide prescription drug coverage, so many seniors do not have prescription drug coverage and must incur these expenditures out-of-pocket.

To bring attention to some of the above mentioned problems, and to consider appropriate action, I have joined my colleagues, Representative MARION BERRY and Representative JIM TURNER in establishing the Prescription Drug Task Force.

Last June I requested that the Government Reform and Oversight Committee investigate whether pharmaceutical companies are taking advantage of older Americans through price discrimination, and, if so, whether this is part of the explanation for the high drug prices being paid by older Americans.

According to a recent Standard & Poor's report on the pharmaceutical industry, ''drugmakers have historically raised prices to private customers to compensate for the discounts they grant to managed care companies. This practice is known as 'cost shifting.' '' I understand that this is the first study which attempts to quantify the extent of price discrimination and how it affects seniors.